

Division of MH/DD/SAS

Service Definitions Question & Answers

February 25, 2004

I. POLICY

1) When can we expect the next revision to the service records manual and updated Medicaid manual?

Answer: It is anticipated that these will be updated approximately 3 months prior to the effective date for the service definition changes reflected on the in 1/15/04 memo and service definition packages. Since we anticipate that the new service definitions will be effective January 1, 2005, we anticipate having the service records and Medicaid manuals revised by October 1, 2004.

2) Will service definitions/maximums be in final service definitions (i.e. community support, developmental therapies)?

Answer: Refer to the Utilization Management section of the definitions. The 3 community support definitions specify the maximums in the initial 3 month period and continued stay criteria require utilization review every 90 days. It is expected that these maximums would apply to re-authorizations as well. Developmental therapies require UM every 180 days. The UM level of care guidelines that will be put in place may specify maximums that can be authorized for individuals in each level of care.

3) Periodic not licensed and direct bill so we do accreditation rather than grandfather in? Work?

Answer: It is anticipated that the individuals who provide services in the basic benefit will be independent practitioners. In our agreement with the Division of Medical Assistance (letter dated October 22, 2003 <http://www.dhhs.state.nc.us/mhddsas/announce/rich-gary10-22-03memo.pdf>) we outlined that independent practitioners providing basic benefit (outpatient) services that are directly enrolled in the Medicaid program through DMA would be automatically deemed to be part of the LME network. If the independent practitioner does not wish to receive referrals from the LME for either Medicaid or non-Medicaid eligible consumers, there will be no need for the LME to do anything. If the independent practitioner and the LME want the practitioner to serve consumers referred to them by the LME – or if the independent practitioner is not directly enrolled in the Medicaid program – the LME will perform a license and credential verification and enter into a simple Memorandum of Agreement outlining referral, scheduling and billing procedures and requirements.

4) The grid has 3 benefit packages-basic, enhanced, and Medicaid. Please explain each benefit level and who is eligible for them?

Answer: The Basic Benefit package includes those services which will be made available to Medicaid-entitled individuals and, to the extent resources are available, to non-target population members according to local business plans. These services are intended to provide brief interventions for individuals with acute needs. The Basic Benefit package is accessed directly by the consumer or through a simple referral from the Local Management

Entity, through its screening, triage and referral system. There are no prior authorization requirements for these services. Referred individuals can access up to 8 visits for adults or 26 visits for children from the Basic Benefit package from any provider enrolled in the North Carolina Medicaid program, or, for non-Medicaid entitled North Carolinians, through the LME's provider network.

Enhanced Benefit services are intended to provide a range of services and supports which are more appropriate for individuals seeking to recover from more severe forms of mental illness and substance abuse and with more complex service and support needs as identified in the person centered planning process. The person-centered plan includes both a proactive and reactive crisis contingency plan. Enhanced Benefit services include services that are comprehensive, more intensive, and may be delivered for a longer period of time. They are integrated services, meaning that individuals typically will need not to receive multiple types of services from multiple providers. They are provided by organizations rather than individual practitioners. These organizations have the necessary clinical, administrative and financial infrastructure in order to serve as a "clinical home" for consumers with complex support and service needs. Most individuals in the Target Population and receiving Enhanced Benefit services will also be receiving a Case Management model of services. These models include Community Support Programs, Assertive Community Treatment, and Intensive Home-Based Services. These models of practice require 24/7/365 availability and coverage, "first responder" capacity for enrolled consumers experience a crisis, and a focus on building recovery skills.

A Medicaid beneficiary is "entitled" under 42 U.S.C. §1396a to access medically necessary services covered in the Medicaid State Plan (i.e., Basic and Enhanced Benefits). A Medicaid beneficiary with a mental health or substance abuse disorder(s) is not required to meet target population criteria in order to access the Basic Benefit, so long as medical necessity for the service is documented. A Medicaid beneficiary meeting target population criteria, is eligible to receive Enhanced Benefit services specified in a person centered plan approved by the LME. The consumer's person centered plan may also include Basic Benefits, e.g., Medication Administration (90782) or Behavioral Health Counseling (H0004) to supplement the Enhanced Benefit services, except when equivalent services are included as part of a comprehensive Enhanced Benefit service being received by the consumer (e.g., Assertive Community Treatment Team). An individual who meets target population criteria, but who is not a Medicaid beneficiary, is given priority for, but does not have a legal entitlement to, Enhanced Benefits and should receive them according to the person centered plan unless the service and funding is not available. There are also some services which DMH/DD/SAS funds will cover, if funds are available and the consumer meets a target population criteria, which Medicaid does not cover.

5) What is the role of "Medical Necessity" in the process of initiating these services?

Answer: For all consumers, services must be medically necessary. Federal Medicaid law prohibits Medicaid reimbursement for any service which is not medically necessary. State policy regarding services paid for with state funds is the same as the federal Medicaid standard. A general definition for medical necessity applicable to Basic Benefit services will be included in the state's utilization management manual. For Enhanced Benefits, medical necessity criteria are embedded in the target population criteria and in the Enhanced Benefits service descriptions, entrance and continued stay criteria, and medical necessity is deemed to be established when the service is recommended in a Person Centered Plan authorized by the LME.

6) Are outpatient and groups being eliminated?

Answer: When medically necessary, individual and group outpatient services may be accessed through the Basic Benefit package (see questions 4 and 5 above for more detail). These services generally meet the service needs of individuals who are not in the target populations. The integrated and comprehensive services in the Enhanced Benefit are specifically designed for individuals in the target populations, and should be utilized to meet most of an individual's service needs (indeed, for many individuals, the Enhanced Benefit could meet virtually all of their service needs). A consumer's Person Centered Plan may supplement the Enhanced Benefits with individual and group outpatient services, except when equivalent services are included as part of a comprehensive Enhanced Benefit service being received by the consumer (e.g., Assertive Community Treatment Team).

The overall benefit design is intended to transition many target population members from traditional office based individual and group services to contemporary evidence-based and emerging best practice services that involve the consumer in key recovery activities, such as skill building, supportive counseling, crisis planning, disease education and symptom management, in settings that are community-based and in the consumer's natural environment. Such services put the consumer's recovery at the center, rather than the practitioner or the procedure.

7) Are the "Y" codes being eliminated across the board?

Answer: Y codes are local billing codes that can no longer be used in a system that meets HIPAA requirements. Many of the services currently designated by "Y" code will remain reimbursable, but will be designated according to the national codes in order to be HIPAA compliant. For example, Facility Based Crisis Program (YP485) will remain as the same service, but will have a new billing code. Some of the services currently designated by Y codes are being eliminated altogether. See the service grid.

8) Has or when will DMA give final approval for the definitions?

Answer: DMH/DD/SAS has been working closely with the Division of Medical Assistance (DMA). The 1/12/04 draft definitions are being reviewed by DMA. The DMA approval process also requires review by their Physician Advisory Group (PAG). When approved by the PAG, DMA must then submit the draft service definitions to the Federal Center for Medicaid and Medicare Services (CMS). That agency has 90 days to approve the services for Medicaid reimbursement. While CMS has approved similar services in other states, it would not be unusual for CMS to ask some clarifying questions of NC which would reset the clock giving CMS 90 days from when answers are received. It is anticipated that the approval process will be completed and service definitions can become effective 1/1/05.

9) Who is responsible for the certification of the providers?

The Division of MH, Division of Facility Services, or the LME?

Answer: LME's will certify qualified providers. The certification process will be set forth in a Commission of MH/DD/SAS rule. To implement the rule, DMH/DD/SAS will issue policies and procedures that will be used by LMEs.

II. LME

(1) Please explain how a Phase III program will be viewed in relation to LME negotiations?

Answer: LMEs are all evolving as they implement their individual Local Business Plans approved by DMH/DD/SAS. There is significant variation within and between LMEs, regardless of the phases. The Phase designation was useful to determine the date of conditional certification. As of January 1, 2005, however, it is not likely that a Phase III program will have developed sufficient capacity to perform all of the functions/services required by the LME contract. Phase I and II programs are more likely to be ready to assume more LME functions and services than Phase III programs. The process of phasing in full-LME functionality will be closely monitored by DMH/DD/SAS. Throughout this transition, DMH/DD/SAS's guiding principles will be first and foremost to ensure that consumers are able to access services, to verify that the LME's approach and capacity has fidelity to the LME functional model, and to determine, with the program/LME, that the LMEs available resources and funding can adequately support the LME's approach. This determination will necessarily involve DMH/DD/SAS and the program/LME accepting that because achieving statewide implementation of the LME model with the administrative funds available requires certain economies of scale, not every program will be able to function as an LME.

Having said that, it is important to recognize that **all** LMEs will be paid based upon the LME Cost Model effective July 1, 2004 and that all LMEs will have to enter into a Performance Contract with DHHS effective that date. In the individual contract negotiations with the LME, it may be that certain performance standards may not apply to Phase III LMEs as quickly as they do to Phase I and II, but the funding and basic contract requirements will be the same.

(2) What is the difference between being a Phase III LME and certification as LME to a Phase I or II?

Answer: The Phase designation only determines the date of conditional certification.

III. BEST PRACTICE

(1) Is ACTT only for Adults? How do we segregate services from ACTT, CBS, and Case management?

What does transition services mean?

Answer: ACTT is a service only for Adults. See the complete service definition for a comprehensive and specific explanation of ACTT. ACTT criteria are different from the criteria for Community Support. CBS and Case Management services will be eliminated when the Enhanced Benefit is effective. Some components of CBS and case management related activities are included in Community Support, but the goals, approach, emphasis, settings, provider requirements are very different. Therefore, it is not accurate to assume that Community Support is the new "code" for CBS and CM. See the complete service definition for a comprehensive and specific explanation of Community Support. Generally, ACTT is a service used for individuals with SPMI, (specifically diagnosis of Schizophrenia, Bi-polar Disorder, Major Depression and Psychotic Disorder NOS.) that have the most difficulty remaining in the community; numerous hospitalizations, involvement with law enforcement. They may experience many crisis situations requiring intervention and may be receiving many hours of the current form of case management service. Community

Support is intended for individuals with any Axis 1 or Axis 2 diagnosis other than a sole developmental diagnosis who also have the characteristics listed above. Community Support should be delivered flexibly and at a frequency and intensity that addresses the individual's unique circumstances.

As an individual achieves progressive stages of recovery, the consumer will likely no longer need the intensive support of ACTT, and should be transitioned to Community Support Team or Community Support. The benefits design allows an individual determined to need to receive both ACTT and Community Support services during a limited time of transition between the services. Many, but not all, individuals will need this. The transitional period is designed to ensure continuity of care, reduce the chances of an inappropriate response to a crisis that could result in hospitalization, and reassure the consumer through the availability of familiar staff while the individual adjusts to the new service and supports and staff.

DMH/DD/SAS recognizes that the transition from current clinical practices to these new service modalities will require significant learning, re-learning, and un-learning. DMH/DD/SAS will arrange for training opportunities that cover not only WHAT these services are but HOW to do them.

Mobile Crisis Management-Utilization Management Section. What are the excepted methods for the Crisis Management Provider to determine if the individual is enrolled with the LME?

Answer: First, it must be emphasized that the provision of crisis management service NEVER requires prior authorization from the LME. That is not the purpose of the provider's contact with the LME seeking enrollment information.

The question describes just one of many critical links necessary for adequate functioning of a community-based crisis response system. One of the most essential responsibilities of an LME is to develop an adequate crisis response system that employs a variety of service modalities and meets the timeliness and setting standards for emergent needs. An adequate system provides consumers, families and communities with more alternatives than hospitalization (local or state institutions) or incarceration in the event of a crisis. The crisis response system and the LME's screening, triage and referral functions must be well integrated but not necessarily co-located. Effective mobile crisis management service is very important, but equally important is an ability to immediately involve the consumer's ongoing service providers. That is why organizations furnishing comprehensive and integrated services, such as ACTT and Community Support, must engage in crisis planning with the consumers they serve, must work with consumers to try to remember to call the ACTT or Community Support in the event of a crisis, and must be prepared to be the first responders to those calls. These organizations go to the consumer even when the crisis management provider is the first responder.

Equally important, the LME should include law enforcement, family protection, hospitals and other general health providers as playing critical roles in the system. For example, the LME should ask law enforcement what it needs the crisis system to do so that they have viable alternatives to incarceration that inspire enough confidence to use them, while at the same time ensuring public safety. The LME should offer training for law enforcement personnel in recognizing behavioral health crises and what to do so that the LME and its providers (especially ACTT and Community Support) can quickly assume responsibility for most consumers, and free law enforcement personnel to go about their duties. All of this is done in the context of preserving public safety, enabling ACTT and Community Support providers

to serve as a clinical home for their consumers and engage in ongoing crisis prevention, through rapid linkages comfort consumers by bringing staff familiar to them, and a community environment that respects the dignity of a person experiencing such a crisis.

For these linkages to work, the LME must have the capacity to inform an inquiring provider of an individual's enrollment status, at the time they ask, and the LME then informs the individual's ACTT or Community Support provider so they can also respond. The LME will need to develop procedures for providers and LME staff to follow when an individual is experiencing a crisis. The procedures must address the information flow the question describes and the information must be rapidly accessible and communicated so that the response is coordinated among the various responders arriving to assist the consumer. Ideally, the LME, its providers, consumers, and entities playing critical roles will collaboratively develop the crisis response system and its procedures. Please also see the Performance Contract section on Access, Screening and Triage.

(3) Diagnostic Assessment-Under staffing requirements, Can an authorizing Care Manager, who is a Q, be considered as part of the "team"?

Answer: The LME Care Manager is not considered part of the Diagnostic Assessment team. The care management function is an LME administrative function.

(4) To coordinate Medicare and Medicaid benefits, is this definition equivalent to a 90801 code?

Answer: Yes, Clinical Evaluation/Intake (CPT Code 90801) is incorporated into the Diagnostic Assessment service definition. However, the diagnostic assessment is a team based assessment for target population individuals.

(5) Does every diagnostic assessment need review by a psychiatrist?

Answer: Each diagnostic assessment will need to be reviewed by a psychiatrist. The psychiatrist shall review all psychiatric and medical functional areas in a consumer's Diagnostic Assessment. These areas include mental status, biopsychosocial history, psychopharmacological information, health related issues, etc. Also see service definition for required components.

(6) Is the Division recommending specific "In-Home" models? What is the recommended Theoretical Orientation for In-Home?

Answer: The service definition describes the in-home models that are reimbursable under the Enhanced Benefit. There are several evidence-base therapies and behavioral intervention models that would meet the requirements of this definition.

(7) The service exclusion between SA IOP and Adult Community Support are not consistent. Please explain?

Answer: Included within the SA IOP service are many components of Community Support, just as individual and group counseling are included with the service. The SA IOP is a fully integrated service. Therefore, Community Support cannot be provided while an individual is receiving SA Intensive Outpatient Program. Following completion of the SA IOP,

Community Support (group and individual) could be appropriate as part of an aftercare plan for the individual.

(8) For all SA services, shouldn't they be consistent with the Mental Health Crisis Responders 24-7-365?

Answer: Not necessarily, for a variety of reasons, although a SA program could choose to offer such capacity. First, often SA crisis calls involve acute intoxication or severe withdrawal. These conditions are primarily medical emergencies requiring immediate medical response, almost always requiring hospitalization or admission to a freestanding detoxification unit. Circumstances involving acute intoxication or severe withdrawal are rarely therapeutic or skill-building moments: The medical issues foreclose any possible resolution relying on a case manager or therapist's intervention. Consider also that the LME's screening, triage and referral function must include 24-7-365 SA capacity and this capacity is an efficient way to respond in these situations by immediately dispatching medical personnel. The LME's STR function and the crisis response system should have procedures to function as a resource for assisting medical or law enforcement personnel with an admission.

In crises involving lower levels of intoxication the mobile crisis management provider could respond. In mild to moderate intoxication situations involving law enforcement due to the individual's criminal actions, incarceration is very often an appropriate response and not necessarily damaging from a therapeutic point of view (it could actually be very instrumental in breaking down the individual's denial system), so long as the facility can monitor the individual for signs of withdrawal. An LME ought to encourage law enforcement personnel to notify the LME in these situations, but primarily for the purpose of care coordination – perhaps arranging for an SA provider to go to the jail in the morning or just prior to release for longer jail stays, in order to facilitate the individual's immediate entry into an organized treatment program.

Finally, effective abstinence-based SA services very often involve a strong emphasis on linking an individual early in the recovery process with a 12 Step or similar self-help recovery group and ensuring that the individual secures a sponsor and a home group. Individuals' successful assimilation into the self-help environment is a primary goal for abstinence-based SA programs and, once accomplished in tandem with a period of continuous abstinence, usually signals transfer to an aftercare level of services or discharge from the SA program altogether. Once assimilated, recovering peers usually serve as "first responders" to individuals experiencing difficulty maintaining abstinence, or experiencing discomfort with their life circumstances. An important part of the aftercare approach is assisting the individual in delaying immediate resolutions of problems until the next self-help meeting or aftercare session. Given that most recovering substance abusers achieve complete independence from professional service providers, and doing so is an important step in the recovery process for many individuals, it would be counter-therapeutic to encourage the individual's continued reliance on the SA provider.

An LME should work to establish relationships with self help groups (these relationships will necessarily be very informal) and could offer volunteering opportunities for recovering individuals that are good for the system and considered by 12 step folks to be sobriety sustaining for the volunteers.

Organizations serving individuals with co-occurring major mental illness and substance abuse disorders, however, ought to have 24-7-365 first responder capacity.

In current service standards to be eliminated, Case Management has not been mentioned?

Answer: Case management is listed under "New or Modified" services as Targeted Case Management. Targeted case management will only be available under the DD Benefit. Case management functions for MH & SA consumers have been incorporated into the Community Support definitions. Please see service definition descriptions.

(10) Haven't seen specific number of supervision hours per staff by CCS. Can you give the number of hours?

Answer: To be certified, the organization must have policies regarding its clinical operations that address the service-specific requirements and include policies for supervision. Supervision policies should reflect the clinicians' licensure and/or certification and codes of ethics, scope of practice, etc.

(11) Are qualifications of staff going to be consistent across service definitions by category?

Answer: The service definitions specify the staff qualified to provide the service. Staff must be part of a certified provider organization and meet the service specific requirements in order to provide the enhanced benefits.

IV. COMMUNITY SUPPORT

(1) In community support definition, is the "first responder" crisis response a requirement in order to bill this service? Can this be contracted out? (24/7/365) for every provider of this service? What is the responsibility of the first responder?

Answer: Each provider of the Community Support service must provide first responder crisis response 24 hour a day, 7 days a week, 365 days a year. First responder crisis response will include providing a means for the recipient of the services to access the provider 24/7/365, the provider to have qualified staff available to determine an appropriate response to the crisis situation (i.e. assess safety issues, determine whether or not it can be handled by the Community Support provider directly or if 911 needs to be called, if a commitment order needs to be obtained, etc.) and qualified staff available to respond the crisis situation.

(2) Why is there not a community support team for children?

Answer: Intensive In-Home Services and MST are the best practice team services for children.

(3) For a child with extended package who isn't appropriate for in-home or MST, but is for community support program, how do they get clinical services?

Answer: Community Support is a clinical service and any additional clinical services required can be authorized as a part of the Person Centered Plan through the Basic and Enhanced Benefit. (Also see I. Policy Question #6 regarding outpatient services.)

(4)What will happen to the people using CBS to fund their residential placement?

Answer: CBS has been incorporated into Community Support and is being eliminated. Community Support will not be billable during a residential placement. The residential service definitions are listed as “under study” so that they can be modified to require the residential provider to provide comprehensive services that include the types of services delivered under Community Support.

(5)What is the review process and timeline for revisiting the 2 week overlap with Community Support and residential, PRTF and Facility Based Crisis?

Answer: The Division is continuing to explore this issue with the Division of Medical Assistance.

(6)For Adult & Child MH/SA services where Case Management is incorporated into a new service, will this allow other agencies to be able to bill case management under their Medicaid agreement while we bill the new services? If so, will this offer an opportunity for re-employment of trained staff beyond private providers and community collaboration on transitions?

Answer: The case management services currently reimbursable by Medicaid to other agencies, i.e. Health Departments and County DSS, are very different from our current MH/SA case management. With the implementation of the new service definitions, no public or private agency will be able to bill MH/SA case management, since it will no longer be a covered service. Non-MH/SA case management services provided by non-Mental Health agencies i.e. public health, DSS will be able to be provided at the same time an individual is receiving a new comprehensive MH/SA service (i.e. Community Support) under the State Plan. If the question is aimed at trying to determine if existing area program staff could transfer to the Health Department or DSS and continue to perform case management in the same way that they have in the area program, the answer is “no.” If the question is whether those other agencies will continue to perform the service that they currently know as case management – which is different from MH/SA case management – the answer is “yes.”

(7)How will consumers who currently need and use up to 56 hours a week of CBS be able to stay in the community with only an average of 20 hours a week community support?

Answer: One of the major reasons for the implementation of new service definitions is to begin providing services that have been proven to be effective in supporting consumers in the community. A consumer who is currently receiving 56 hours of CBS – if that amount of support is truly medically necessary – clearly needs a more intensive service. They would be a candidate for Community Support Team or ACT Team service for Adults or Intensive In-Home Services or Multisystemic Therapy (MST) for children. Years of research have proven that additional quantities of the wrong service do not achieve the positive outcomes that the appropriate amount of the appropriate service can achieve.

(8)Are community support efforts applied to the rest home environment?

Answer: Community Support cannot be provided in a rest home environment.

(9) How does this apply to people in day treatment and residential services?

Answer: Community Support cannot be provided while someone is receiving day treatment or most residential services. Please see service exclusions under Community Support.

(10) Define transition periods?

Answer: The transitional period is designed to ensure continuity of care, reduce the chances of an inappropriate response to a crisis that could result in hospitalization, and reassure the consumer through the availability of familiar staff while the individual adjusts to the new service and supports and staff. Please see specific service definitions for transition timeframes.

(11) Community Support Adults Section-Add "unless specific authorizations for exceeding this limit is approved" (to last sentence page 6- Utilization Management).

Answer: The "unless specific authorizations for exceeding this limit is approved" only applies to the Child Community Support definition based on EPSDT requirements. The UM document (please see the Draft Performance Contract on the Division Website) will be used as guidance for determining appropriate limits. Additionally, if an individual requires additional limits, a higher level of care should be considered.

V. DEVELOPMENTAL DISABILITIES

1. Why do some DD services have a requirement to complete NC-SNAP and ASAM when the service is specific to this population? (ex: ADVP, Community Rehab)?

Answer: Only the instrument appropriate to the specific population is to be used. The NC-SNAP is the tool chosen by the Division for assessment of intensity of supports needed by individuals with Developmental Disabilities.

2. Since case support is on the list of services to be eliminated with disposition of "Incorporated into Community Supports", what about "Case Support" provided to DD consumers?

Answer: For DD consumers Case Support functions are incorporated within the Targeted Case Management definition.

3. Will there be a cap on the amount of Developmental Therapies or Targeted Case Management a consumer may be provided within a period of time?

Answer: Caps on these service definitions will be outlined in UM, Continued Stay and Discharge Criteria as outlined within the definitions. LMEs are charged with the responsibility of Utilization Management functions to insure appropriate service delivery.

4. Personal Care definition no longer states that this service cannot be provided in a group home setting. Is there consideration of this limitation being lifted?

Answer: Personal Care services may not be provided in a group home setting.

- 5. In definitions for PC, IHA, and transportation the continued stay criteria is the same as the habilitative services. Is this correct?**

Answer: Transportation definition does not have Continued Stay Criteria, as it is not applicable. Although PC and IHA are support in nature rather than habilitative the basic criteria applies.

- 6. What is the difference between the separate Aug Com definition and Aug. Comm section (#4) under the Specialized Medical Equipment and Supplies definition?**

Answer: The proposed new CAP-MR/DD service definitions continue to be in draft form. Final definitions will include a separate definition for Aug Com with the deletion of the Aug Com section under Specialized Medical Equipment and Supplies.

- 7. Please explain why elements of supervision and support are not included in Residential Support definition, as they are included in the Home and Community Supports definition?**

Answer: Since Residential Supports are provided in licensed residential settings or AFL payment is not made for routine supervision or supports which are typically provided by the group home provider or AFL provider.

- 8. Several definitions (i.e. Consumer/Family Training) refer to consumer driven supports. Will there be a separate definition for that?**

Answer: There is not a separate definition for consumer driven supports. The Division supports the development of best practice approaches to self-direction and is involved in and planning a number of activities that will provide more self-directed options and information for the future.

- 9. Are the definitions for Home and Community Supports and Residential Supports going to be inclusive of transportation?**

Answer: The rate for Home and Community Supports and Residential Supports will include transportation.

- 10. Why isn't DD respite included as Medicaid reimbursable service?**

Answer: Although the possibility of respite being reimbursed through Medicaid is currently under study; at this time Medicaid does not reimburse for this service.

- 11. Is Developmental Therapy for children and adults? If just for adults, what service replaces CBS for children? What constitutes a "developmental disabilities provider" under provider requirements?**

Answer: This definition is being revised to include children. Definitions will also be revised to state that services are to be "delivered by practitioners employed by a provider organization, which meets standards established by the Division of MH/DD/SAS". Reference to DD provider will be removed.

12.Social inclusion. Is Medicaid taking the Thomas S.? What do we do with geriatric population?

Answer: Social Inclusion functions are incorporated into the new service definitions of Community Supports, Developmental Therapy, and Home and Community Supports or Residential Supports, depending on the population served. All of these services have as their intent to support community membership and connections. These services are also applicable to the geriatric population per their person centered plan. In addition, Adult Day Health is available for the aged through the waiver.

13.Why is an Assoc. Professional overseeing the DD case plan and for others a Q is required?

Answer: Staffing requirements for Targeted Case Management and waiver Case Management includes both a Qualified Professional or an Associate Professional. Associate Professional must be under supervision of a Qualified Professional.

14.In questions concerning the proposed new CAP-MR/DD service definitions, what does funding mean to the LME to operate a treatment environment?

Answer: LME's will not operate a treatment environment, but will manage the funding for MH/DD/SAS services.

15.Are these new services definitions a part of the new CAP waiver that will need to be approved by CMS before implementation? What is the status and expected implementation date?

Answer: Yes, they will need to be approved by CMS prior to implementation. The draft wavier is currently being finalized by DMH/DD/SAS for review by DMA.

16.Is it still planned that the new waiver, CAP would convert to use the same agency plan of care as everyone else is using? If so, the new case management definition would need revamping to remove the references to the case management-monitoring schedule.

Answer: There is no change with the plan of care with the draft of the new wavier.

VI. MEDICAL

(1) Please comment on funding for lab work necessary to appropriately manage (psychiatric needs) medical RX (ex. Li , Clozaril)?

Answer: The proposed changes in the service definitions does not address funding for lab work. We recognize that this is an on-going concern for many consumers who are not able to pay.

(2) Please comment on funding for medication?

Answer: The proposed changes in the service definitions does not address funding for medication. At this time, the only specific State DMH/DD/SAS funding to pay for medication for indigent consumers who are not covered by Medicaid is the Atypical Anti-psychotic

Medication fund. This is an on-going concern for many consumers who are not able to pay and who are prescribed medications other than the atypical anti-psychotics